Bureau of Health Care Quality & Compliance Accepted MFlynn 3/13/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN160AGC	A. BUILDING _____ B. WING _____	02/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY GROUP CARE CENTRE	1807 E LONG ST CARSON CITY, NV 89701

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Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey initiated in your facility on 2/2/09 and completed on 2/9/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 38 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 30. Ten resident files were reviewed and nine employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 105 SS=E	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 2/2/09, the facility failed to ensure 1 of 9 caregivers met background check requirements (Employee #1).	Y 105	RECEIVED MAR 10 2009 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA Employee #1 (after 5 years of employment) has been re-fingerprinted. Attach #1	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this state[illegible]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Dany Lopez SIGN HERE DATE 3/9/09

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Y 105	Continued From page 1 This was a repeat deficiency from the 2/12/08 annual State Licensure survey. Severity: 2 Scope: 2	Y 105	Y105 C.P: √(2/3/09) 1) All employees that need fingerprints every 5 years will be identified at staff meeting of the year (every Jan 10 & each year) 2) (to identify/announce during the monthly meeting the prints needed for the month. 3) Employee to obtain clearance to file results 4) 5) Administrator to review all records.	
Y 255 SS=F	449.217(6)(a)(b) Permits - Comply with NAC 446 NAC 449.217 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Bureau of Health Protection Services of the Division. This Regulation is not met as evidenced by: Based on observation, record review and interview on 2/2/09, the facility did not ensure its kitchen complied with the standards of 446 of NAC in the following areas: improper food labeling; outdated foods, no pH test kits for sanitizing solutions; scoops in the flour and sugar bins; and person-in-charge lacking ServeSafe (or similar) training. Severity: 2 Scope: 3	Y 255	Y255 C.P 1) All Staff – notified for not leaving any scoop on the flour and sugar bin, memo attached #I For implementation, we use form, att. III √2/3/09 2) We have 2 cooks – Employee #3 is SERVE-SAFE trained Employee #– (second cook – is scheduled for SERVE-SAFE training on 3/12/09. Will send staff for SERVE-SAFE training as needed. 3) We use HOT-WATER sanitizing system so we normally do not need pH test kits. The HOT WATER sanitizing system is monitored daily for temp (180° or higher) and is monitored quarterly by the Ecolab technician. (Attach #IV)	
Y 257 SS=C	449.217(7) Inspections-Approved by BHPS	Y 257		

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Y 257	Continued From page 2 NAC 449.217 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Bureau of Health Protection Services of the Division and the state and local fire safety authorities. This Regulation is not met as evidenced by: Based on observation and interview on 2/2/09, the facility did not ensure its kitchen equipment complied with commercial-grade NSF standards (refrigerator and toaster). Severity: 1 Scope: 3	Y 257	Y257 A refrigerator and toaster, commercial grade will be purchased by 4/30/09 order shows delivery by 4/1/09 MF	
Y 274 SS=C	449.2175(5) Service of Food - Substitutions NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous place during the service of the meal. This Regulation is not met as evidenced by: Based on record review and interview on 2/2/09, the facility did not ensure menu substitutions were documented and kept on file for 90 days. Severity: 1 Scope: 3	Y 274	All menu substitution will be documented and kept on file for 90 days. Att. menu 4/3/09 MF	

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Y 280	Continued From page 3	Y 280		
Y 280 SS=F	449.2175(10)(a)-(d) Dietary Consultant & Services	Y 280		

NAC 449.2175
10. The person providing services pursuant to subsection 9 shall provide those services not less than once each calendar quarter. The administrator of the facility shall keep a written record of the consultations on file at the facility. The consultations must include:
(a) The development and review of weekly menus.
(b) Training for the employees who work in the kitchen.
(c) Advice regarding compliance with the nutritional program of the facility.
(d) Any observations of the person providing the services regarding the preparation and service of meals in the facility to ensure that the facility is in compliance with the nutritional program of the facility.

The Dietician reviews the menu, discusses with kitchen staff any changes. 3/9/09
EVCC will require the Dietician to fill up forms developed for their purpose (attached).

This Regulation is not met as evidenced by:
Based on record review and interview on 2/2/09, the facility could not provide evidence of dietary consultant services for 3 out of the last 4 quarters.

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Y 280	Continued From page 4 Severity: 2 Scope: 3	Y 280		
Y 450 SS=D	449.231(1) First Aid and CPR NAC 449.231 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. This Regulation is not met as evidenced by: Based on record review on 2/2/09, the facility did not ensure that 1 of 9 caregivers received first aid and cardiopulmonary resuscitation (CPR) training within thirty days of employment (Employee #8). Severity: 2 Scope: 1	Y 450	Employee #8 has been trained. Attached card – copy Date of Employment: 11/20/08 First Aid/CPR training – annually scheduled every January In-House or On-Site Training By MASON (annually)	1/2009 MK
Y 773 SS=E	449.2726(1)(a)(1)(2) 449.2726(1)(a)(b) Diabetes NAC 449.2726 1. A person who has diabetes must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless:	Y 773		

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Y 773	Continued From page 5 (a) The resident's glucose testing is performed by: (1) The resident himself, without assistance; or (2) A medical laboratory licensed pursuant to chapter 652 of NRS; and This Regulation is not met as evidenced by: Based on record review, resident interviews and staff interviews on 2/2/09, the facility failed to ensure that blood glucose testing for 1 of 2 diabetic residents was performed by the resident without assistance (Resident #1). Severity: 2 Scope: 2	Y 773	We will not admit any diabetic client who can not do her own tests & injection Diabetic Resident must be able to do their own tests & injection. Both residents are doing their own tests.	2/4/09 NK 2/7/09 NK
Y 850 SS=G	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident is the resident's physician is not available. This Regulation is not met as evidenced by: Based on interview and record review from 2/2/09	Y 850	Resident #4 is currently under the care of Home Health Nurse. Admission Agreement revised to add a statement regarding EVCG's responsibility to arrange for medical care (emergency or non emergency) Attach: ____	2/6/09 NK 3/1/09 NK

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Y 850	Continued From page 6 to 2/9/09, the facility failed to ensure the physician of 1 of 10 residents was notified of the resident's change in condition (Resident #4). Findings include: Resident #4 moved from California and was admitted to the facility on 4/18/08. Office visit notes dated 2/8/08 by the resident's California physician indicated the resident had a recurring pressure ulcer on her right heel. The physician indicated that on the day of the office visit, the resident had a Stage II pressure ulcer on the right heel and that the resident was incapable of performing her own personal care. Employee #7, a caregiver, reported on 2/2/09 that Resident #4 did not have a primary physician in Nevada when she was admitted to the facility and the daughter was trying to set up an initial appointment with one for her mother. The resident was seen by her new Nevada physician on 5/13/08. There were no notations in the office visit forms indicating the physician had been informed the resident had a pressure ulcer on her right heel. An Initial Nursing Assessment from a wound clinic dated 5/16/08 was found in Resident #4's file. It was later determined the daughter, who was a registered nurse, made the referral to the wound clinic for her mother. The clinic assessment indicated Resident #4 had a non-healing un-stageable wound on her right heel that was two months old. Wound clinic documents revealed the pressure ulcer was cultured and debrided on 5/16/08. The wound was found to be infected and antibiotics were prescribed for the resident. Review of the facility documents found no evidence the resident's	Y 850		

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Y 850	Continued From page 7 Nevada physician was notified by the facility about the resident's heel wound. Six months after Resident #4's initial visit to the wound clinic, clinic records dated 11/3/08 showed the resident's wounds had become worse. There was no evidence in the facility records that the resident's physician was notified by the facility about the resident's worsening condition. The facility administrator was interviewed on 2/5/09. The administrator admitted she did not obtain medical treatment and wound management for the resident once she became aware of the pressure ulcer on the resident's right heel. See also TAG Y858 Severity: 3 Scope: 1	Y 850	Facility Program of informing family of any need of medical care is re-constructed to include a sign-up sheet (Admission Agreement - addendum). Medical treatment will be immediately sought upon start ~~Existence~~ of wound. Time to follow through.	3/6/09 MR
Y 858 SS=H	449.274(4)(c) Medical Care / Records NAC 449.274 4. the facility shall ensure that appropriate medical care is provided to the resident by: (c) A medical professional. This Regulation is not met as evidenced by: Based on interviews and record review from 2/2/09 to 2/9/09, the facility failed to ensure appropriate medical care was provided to 1 of 10 residents in the facility (Resident #4). Findings include:	Y 858	See Y850 Facility will ensure appropriate medical care to all residents.	MR 3/1/09 Admission Agreement new form

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Y 858	Continued From page 8	Y 858		

Resident #4 was admitted to the facility on 4/18/08. The resident had been living in a facility in California and was moved to this Nevada facility by her daughter. Office visit notes by the resident's California physician dated 2/8/08 indicated the resident had a recurring pressure ulcer on her right heel. The physician indicated that on the day of the office visit, the resident had a Stage II pressure ulcer on the right heel and that the resident was incapable of performing her own personal care.

Employee #7, a caregiver, reported on 2/2/09 that she conducted the admission interview with Resident #4's daughter who was the Power of Attorney (POA) for the resident. The caregiver stated she informed the daughter the facility did not have staff that could provide wound care management for the resident's heel. The caregiver reported the daughter told her that she was a Registered Nurse (RN) and could provide wound care for the resident. The employee reported the resident did not have a primary physician in Nevada and the daughter was trying to set up an initial appointment with one for her mother.

Resident #4 was seen by her new Nevada physician on 5/13/08. There were no notations on the office visit forms indicating the physician had been informed of the pressure ulcer on the resident's right heel.

A wound clinic Initial Nursing Assessment dated 5/16/08 was found in Resident #4's file. It was later determined the daughter made the referral to the wound clinic for her mother. The clinic assessment indicated Resident #4 had a non-healing un-stageable wound on her right heel

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Y 858	Continued From page 9	Y 858		

that was two months old. Wound clinic documents revealed the pressure ulcer was cultured and debrided on 5/16/08. The wound was found to be infected and antibiotics were prescribed for the resident. Wound care instructions dated 5/16/08 from the clinic were found in the facility. Prescribed products used for wound treatment were also found in the facility. There was no evidence in the facility or wound clinic records that home health nursing care was ordered for treatment of the wounds at the facility.

Six months after Resident #4's initial visit to the wound clinic, clinic records dated 11/3/08 showed the resident's wounds had become worse. The resident's previous right heel wound was now a Stage III pressure ulcer and a second Stage III pressure ulcer had developed on the right heel. The resident had developed an unstageable pressure ulcer on the left heel and a Stage II pressure ulcer on her left fifth toe. The four wounds were cultured during the visit and were found to be infected so antibiotics were ordered. Wound clinic notes showed the clinic debrided the resident's foot wounds on 11/24/08. There was no evidence in the facility or wound clinic records that home health nursing care was ordered to provide continued treatment of the wounds from 11/24/08 to the date of the survey.

Employee #11, a caregiver, reported on 2/5/09 that Resident #4's daughter instructed him on how to perform the wound care and dressing changes on the resident's right heel. The employee reported he followed the daughter's instructions because the daughter was not coming to the facility to do the treatments. The employee related that if he did not do the dressing changes and wound treatments on the resident's heel, he did not think it would have

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Y 858	Continued From page 10 been done. Review of Employee #11's record found he was not a medical professional and had no formal training in wound care management. The facility administrator was interviewed on 2/5/09 and asked why she admitted a resident who had a problem with recurring pressure ulcers. The administrator indicated that she did not have knowledge of Resident #4's previous wounds. The administrator reported she thought the pressure ulcer developed on the resident's heel, "during the long drive from the California." The distance of the drive was approximately 200 miles. The administrator admitted she did not obtain medical treatment and wound management for the resident once she became aware of the pressure ulcer on the resident's right heel. The administrator stated the daughter of the resident was a RN and told them she was going to do the nursing care on the wound. Resident #4's daughter was interviewed on 2/6/09. The daughter stated that she worked full time and was too busy to go to the facility on "every shower-day" to treat and dress her mother's wound. The resident's shower days were scheduled two to three times a week depending on how soiled her dressings were. The daughter stated she taught the staff at the facility how to do treat and dress the resident's heel wound. The daughter reported no one in the facility told her that the facility staff were not qualified or allowed to perform skilled care such as wound management. This was a repeat deficiency from the 6/18/08 Complaint Investigation survey. Severity: 3 Scope: 2	Y 858		

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Y 884	Continued From page 11	Y 884		
Y 884 SS=H	449.2742(8) Medication Administration NAC 449.2742 8. An employee of a residential facility shall not draw medication into a syringe or administer an injection unless authorized by law to do so. This Regulation is not met as evidenced by: Based on record review and interviews on 2/2/09, caregivers were drawing up insulin into syringes for 2 of 2 diabetic residents (Resident #1 and #6). Findings include: Resident #6 reported staff prepared the insulin syringe for her, but she injected it herself. The physician's order for the resident indicated Levemir was to be given twice daily at 55 AM/45 PM. Employee #11 reported that caregivers drew up insulin into syringes for the two diabetic residents (#1 and #6). The employee further stated the residents used to have pre-filled pens, but they could not afford them any longer. None of the caregivers were medical or nursing professionals authorized to draw medications into syringes. Severity: 3 Scope: 2	Y 884	The residents - (2) who has diabetes have been doing their own tests & injection. Staff was instructed not to do this for them. Past actions - were attempts to pamper the residents.	2/2/09 MF
Y 896 SS=C	449.2744(1)(b)(2) Medication / MAR	Y 896		

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Y 896	Continued From page 12 NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (2) The date and time that the medication was administered. This Regulation is not met as evidenced by: Based on record review and staff interviews at 12:00 noon on 2/2/09, the facility did not ensure that a record of medications administered on 2/2/09 at 8:00 AM was completed for all residents in the facility. This is a repeat deficiency from 2/12/08 annual State Licensure survey. Severity: 1 Scope: 3	Y 896	See memo — all medication are recorded immediately after dispensing.	2/2/09